WASHINGTON COUNTY CORP.

☐ ENROLLMENT APPLICATION (Complete entire application.)
☐ CHANGE FORM (Complete shaded boxes and all changed information.)

Educators Mutual Insurance Association • 852 East Arrowhead Lane • Murray, Utah 84107-5298 • 262-7476

SPECIFIC JOB TITLE			DATE OF EMPLOYMENT	POLICY NUMBER (FOR OFFICE USE ONLY)	
LAST NAME	FIRST	INITIAL	EMPLOYEE SOCIAL SECURITY NO.	EMPLOYEE DATE OF BIRTH	E-MAIL ADDRESS
ADDRESS/STREET NO.		CITY & STATE	ZIP CODE	HOME PHONE	
				BUSINESS PHONE	
BENEFICIARY		RELATIONSHIP	CONTINGENT BENEFICIARY		RELATIONSHIP

EMPLOYMENT STATUS: ☐ ACTIVE EMPLOYEE ☐ RETIRED (RETIREMENT DATE / /) ☐ COBRA

OTHER INSURANCE INFORMATION (THIS SECTION MUST BE COMPLETED)

Do you, your spouse, or dependents have other medical or dental coverage (including Medicare)? ☐ Yes ☐ No

If so, what type of coverage? ☐ Medicare Part A ☐ Medicare Part B ☐ Other Medical ☐ Dental

If so, what is the coverage classification? ☐ Single ☐ Couple ☐ Family

Name of Insured _____

Insured's Social Security Number _____

Name of Other Insurance Company _____

Please provide any of the following information you may have:

Group and/or Policy Number _____

Effective Date _____

Insurance Company Phone Number _____

COVERAGE DESIRED

Check only employer-sponsored benefits for your employee classification. NOTIFY EMPLOYER WITHIN 31 DAYS OF ANY CHANGE (marriage, first birth, divorce, etc.).

1. GROUP MEDICAL COVERAGE
   - ☐ Employee only
   - ☐ Employee + one dependent
   - ☐ Family

2. DENTAL COVERAGE - PREMIER PPO
   - ☐ Employee only
   - ☐ Employee + one dependent
   - ☐ Family

- ☐ New Enrollment
- ☐ Add Dependent
- ☐ Cancellation
- ☐ Delete Dependent
- ☐ Change of Coverage
- ☐ Beneficiary Change
- ☐ Special Enrollment
- ☐ Current Salary $ _____
- ☐ Other: _____

WAIVER OF GROUP COVERAGE

I choose not to participate in the following group benefits that have been offered and hereby waive such coverage. I understand that I may later apply for these benefits if I experience a special enrollment situation (i.e., marriage, divorce, birth, death, adoption, placement for adoption, or loss of other insurance coverage), or during my employer's next open enrollment period.

☐ MEDICAL COVERAGE ☐ DENTAL INSURANCE

_____

Signature of Applicant for Waiver Only — Date

RELATIONSHIP TO EMPLOYEE	RELATION TO EMPLOYEE	LIST ALL FAMILY MEMBERS TO BE COVERED	SEX	BIRTHDATE MO	BIRTHDATE DAY	BIRTHDATE YR	SOCIAL SECURITY NUMBER	SAME ADDRESS AS EMPLOYEE?
CODE KEY: I: Self, S: Spouse, N: Natural Child, SC: Step Child, A: Adopted, O: Other (Describe)	I	1. Employee						yes
		2.						
		3.						
		4.						
		5.						
		6.						
		7.						

Please note: Plans may be subject to binding arbitration provisions.

ELECTION TO PARTICIPATE

I hereby apply for coverage to which I may be entitled or to which I may become entitled under the terms of the agreement in the policies issued by Educators Mutual Insurance Association and/or its subsidiary companies. I accept the terms of the group agreement between my employer and the Plan and appoint my employer to act as agent in my behalf. I authorize the deduction from my earnings of any contribution I am required to make toward the cost of this coverage. I agree that the proposed coverage shall not take effect until this application has been accepted by Educators Mutual Insurance Association and/or its subsidiary companies as applicable and shall become effective only in accordance with the provisions of such agreements, group policy, or policies. I authorize Educators Mutual Insurance Association and/or its subsidiary companies to share medical information concerning me or my family with any health care provider providing health benefits within the scope of the group contract. I understand that any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Signature of Applicant — Application Date — Enrollment Date — Approved By